

FOR OHF USE										LL1										IMPORTANT NOTICE									
																				THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.									
										2001																			
										STATE OF ILLINOIS																			
										DEPARTMENT OF PUBLIC AID																			
										FINANCIAL AND STATISTICAL REPORT FOR																			
										LONG-TERM CARE FACILITIES																			
										(FISCAL YEAR 2001)																			
I. IDPH Facility ID Number:										0011528										II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER									
Facility Name:										MEADOW MANOR																			
Address:										800 Mc ADAM DRIVE										TAYLORVILLE									
										Number										City									
County:										CHRISTIAN										Zip Code									
Telephone Number:										(217) 824-2277										Fax # (217) 287-7763									
IDPA ID Number:										370840530001																			
Date of Initial License for Current Owners:										1963																			
Type of Ownership:																				Officer or Administrator of Provider									
																				(Signed)									
																				(Type or Print Name)									
																				JERRY W. JENNINGS									
VOLUNTARY, NON-PROFIT										X PROPRIETARY										GOVERNMENTAL									
																				(Title)									
Charitable Corp.										Individual										State									
Trust										Partnership										County									
IRS Exemption Code										Corporation										Other									
										X "Sub-S" Corp.										Paid									
										Limited Liability Co.										Preparer									
										Trust										(Print Name and Title)									
										Other										(Firm Name & Address)									
																				(Telephone)									
																				Fax # ()									
In the event there are further questions about this report, please contact:																				MAIL TO: OFFICE OF HEALTH FINANCE									
Name: JERRY W. JENNINGS										Telephone Number: (217) 787-8530										ILLINOIS DEPARTMENT OF PUBLIC AID									
																				201 S. Grand Avenue East									
																				Springfield, IL 62763-0001									
																				Phone # (217) 782-1630									

Facility Name & ID Number		MEADOW MANOR		STATE OF ILLINOIS		Page 2					
						#	0011528	Report Period Beginning:	05/01/00	Ending:	04/30/01
III. STATISTICAL DATA				D. How many bed-hold days during this year were paid by Public Aid?							
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds				(Do not include bed-hold days in Section B.)							
				E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)							
1				2				3			
4				5				6			
Beds at Beginning of Report Period				Licensure Level of Care				Beds at End of Report Period			
1				2				3			
2				3				4			
3				4				5			
4				5				6			
5				6				7			
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90				91				92			
91				92							

					STATE OF ILLINOIS					Page 3	
	Facility Name & ID Number	MEADOW MANOR			# 0011528	Report Period Beginning:	05/01/00	Ending:	04/30/01		
	V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)										
		Costs Per General Ledger				Reclass-ification	Reclassified	Adjust-ments	Adjusted	FOR OHF	USE ONLY
	Operating Expenses	Salary/Wage	Supplies	Other	Total		Total		Total		
	A. General Services	1	2	3	4	5	6	7	8	9	10
1	Dietary	110,670	13,962	3,481	128,113		128,113		128,113		1
2	Food Purchase		101,732		101,732		101,732	(2,053)	99,679		2
3	Housekeeping	37,368	13,220		50,588		50,588		50,588		3
4	Laundry	24,691	15,278		39,969		39,969		39,969		4
5	Heat and Other Utilities			84,642	84,642		84,642	(4,200)	80,442		5
6	Maintenance	38,111	19,801	32,324	90,236		90,236	1,101	91,337		6
7	Other (specify):* Utility Workers	13,724			13,724		13,724		13,724		7
8	TOTAL General Services	224,564	163,993	120,447	509,004		509,004	(5,152)	503,852		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	755,191	32,177	3,112	790,480	(5,107)	785,373	789	786,162		10
10a	Therapy	16,780	62		16,842		16,842		16,842		10a
11	Activities	21,254	1,691		22,945		22,945		22,945		11
12	Social Services	18,710		2,396	21,106		21,106		21,106		12
13	Nurse Aide Training	4,068	69	5,131	9,268		9,268		9,268		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	816,003	33,999	22,639	872,641	(5,107)	867,534	789	868,323		16
	C. General Administration										
17	Administrative	49,631		8,132	57,763	861	58,624	33,072	91,696		17
18	Directors Fees										18
19	Professional Services			155,020	155,020		155,020	(145,559)	9,461		19
20	Dues, Fees, Subscriptions & Promotions			10,750	10,750		10,750	(4,855)	5,895		20
21	Clerical & General Office Expenses	17,280	6,310	6,454	30,044		30,044	16,100	46,144		21
22	Employee Benefits & Payroll Taxes			177,161	177,161		177,161	10,086	187,247		22
23	Inservice Training & Education			1,223	1,223		1,223	77	1,300		23
24	Travel and Seminar			1,621	1,621	(889)	732	1,414	2,146		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			63,633	63,633		63,633	346	63,979		26
27	Other (specify):*			15,250	15,250		15,250	(15,250)			27
28	TOTAL General Administration	66,911	6,310	439,244	512,465	(28)	512,437	(104,569)	407,868		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,107,478	204,302	582,330	1,894,110	(5,135)	1,888,975	(108,932)	1,780,043		29
	*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.										
	NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.										

STATE OF ILLINOIS										Page 5				
Facility Name & ID Number		MEADOW MANOR		# 0011528		Report Period Beginning:		05/01/00		Ending:		04/30/01		
VI. ADJUSTMENT DETAIL				A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.										
				In column 2 below, reference the line on which the particular cost was included. (See instructions.)										
		1		2		3		B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)						
NON-ALLOWABLE EXPENSES		Amount		Refer- ence		OHF USE ONLY								
1	Day Care		\$			\$		1				1	2	
2	Other Care for Outpatients							2				Amount	Reference	
3	Governmental Sponsored Special Programs							3	31	Non-Paid Workers-Attach Schedule*	\$		31	
4	Non-Patient Meals							4	32	Donated Goods-Attach Schedule*			32	
5	Telephone, TV & Radio in Resident Rooms							5		Amortization of Organization &				
6	Rented Facility Space		(4,200)	5				6	33	Pre-Operating Expense			33	
7	Sale of Supplies to Non-Patients							7		Adjustments for Related Organization				
8	Laundry for Non-Patients							8	34	Costs (Schedule VII)	(76,518)	Various	34	
9	Non-Straightline Depreciation		5,245	30				9	35	Other- Attach Schedule	Sch XIX-H Column 8	447	6	
10	Interest and Other Investment Income		(1,833)	32				10	36	SUBTOTAL (B): (sum of lines 31-35)		(76,071)	36	
11	Discounts, Allowances, Rebates & Refunds		(832)	21				11		(sum of SUBTOTALS				
12	Non-Working Officer's or Owner's Salary							12	37	TOTAL ADJUSTMENTS (A) and (B))		(99,914)	37	
13	Sales Tax		(2,998)	27				13						
14	Non-Care Related Interest							14	*These costs are only allowable if they are necessary to meet minimum					
15	Non-Care Related Owner's Transactions							15	licensing standards. Attach a schedule detailing the items included					
16	Personal Expenses (Including Transportation)							16	on these lines.					
17	Non-Care Related Fees		(60)	20				17						
18	Fines and Penalties		(7,215)	27				18	C. Are the following expenses included in Sections A to D of pages 3					
19	Entertainment							19	and 4? If so, they should be reclassified into Section E. Please					
20	Contributions							20	reference the line on which they appear before reclassification.					
21	Owner or Key-Man Insurance							21	(See instructions.)		1	2	3	4
22	Special Legal Fees & Legal Retainers							22			Yes	No	Amount	Reference
23	Malpractice Insurance for Individuals							23	38	Medically Necessary Transport.			\$	
24	Bad Debt		(4,794)	27				24	39					
25	Fund Raising, Advertising and Promotional		(4,013)	20				25	40	Gift and Coffee Shops				
	Income Taxes and Illinois Personal								41	Barber and Beauty Shops				
26	Property Replacement Tax		(243)	27				26	42	Laboratory and Radiology				
27	Nurse Aide Training for Non-Employees							27	43	Prescription Drugs				
28	Yellow Page Advertising		(847)	20				28	44	Exceptional Care Program				
29	Other-Attach Schedule	VENDING	(2,053)	2				29	45	Other-Attach Schedule	OXYGEN	X	5,135	10
30	SUBTOTAL (A): (Sum of lines 1-29)		\$	(23,843)		\$		30	46	Other-Attach Schedule				
									47	TOTAL (C): (sum of lines 38-46)		\$	5,135	
OHF USE ONLY														
48		49		50		51		52						

STATE OF ILLINOIS				Page 5A	
	MEADOW MANOR				
	ID#	0011528			
Report Period Beginning:	05/01/00				
Ending:	04/30/01				
				Sch. V Line	
	NON-ALLOWABLE EXPENSES		Amount	Reference	
1		\$			1
2					2
3					3
4					4
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49	Total				49

[illegible]

										STATE OF ILLINOIS										Page 6																																																																															
Facility Name & ID Number										MEADOW MANOR										# 0011528		Report Period Beginning: 05/01/00		Ending: 04/30/01																																																																											
VII. RELATED PARTIES																																																																																																			
A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary																																																																																																			
1 OWNERS										2 RELATED NURSING HOMES										3 OTHER RELATED BUSINESS ENTITIES																																																																															
Name										Ownership %										Name										City										Name										City										Type of Business																																							
SEE ATTACHED SCHEDULE - PAGE 25																				D'ADRIAN CONVALESCENT CENTER, INC										GODFREY										Nrsg Home Mngrs										SPRINGFIELD										MANAGEMENT																																							
																				HILLTOP NURSING HOME, INC										CHARLESTON																																																																					
																				JACKSONVILLE CONVALESCENT CENTER										JACKSONVILLE																																																																					
																				MENARD CONVALESCENT CENTER, INC										PETERSBURG																																																																					
																				SUNRISE MANOR OF VIRDEN, INC										VIRDEN																																																																					
B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.																																																																																																			
										<input checked="" type="checkbox"/> YES										<input type="checkbox"/> NO																																																																															
If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.																																																																																																			
1										2										3 Cost Per General Ledger										4										5 Cost to Related Organization										6										7										8 Difference:																													
Schedule V										Line										Item										Amount										Name of Related Organization										Percent of Ownership										Operating Cost of Related Organization										Adjustments for Related Organization Costs (7 minus 4)																													
1										V										19 MANAGEMENT FEE										\$ 154,557										NURSING HOME MANAGERS, INC.										81.83%										\$										\$ (154,557)										1																			
2										V										Var SEE ATTACHED SCHEDULE																				NURSING HOME MANAGERS, INC.																				69,149										\$										69,149										2									
3										V										19 ACCOUNTING																				NURSING HOME MANAGERS, INC. - DIRECT ALLOCATION																				8,890										\$										8,890										3									
4										V										24 TRAVEL										636										TO TRANSFER 31% OF HOME OFFICE TRAVEL																														(636)										4																			
5										V										17 ADMINISTRATIVE TRAVEL																				TO ADMINISTRATIVE PER PRIOR DESK REVIEW																				636										\$										636										5									
6										V																																																																																6									
7										V																																																																																7									
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13										V																																																																																13									
14										Total																				\$ 155,193																				\$ 78,675										\$ *										(76,518)										14																			
* Total must agree with the amount recorded on line 34 of Schedule VI.																																																																																																			

				STATE OF ILLINOIS						Page 7		
Facility Name & ID Number		MEADOW MANOR		#	0011528	Report Period Beginning:		05/01/00	Ending:	04/30/01		
VII. RELATED PARTIES (continued)												
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.												
NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.												
	1	2	3	4	5	6		7		8		
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column		
				Ownership	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Reference		
1	SAM KLEIN	PRESIDENT		44.81					\$ 1,890	17 - 7	1	
2	H. RAYMOND KLEIN	OWNER		37.02					1,891	17 - 7	2	
3											3	
4											4	
5			SAM KLEIN AND H. RAYMOND KLEIN WERE PAID BY NURSING HOME MANAGERS, INC. A RELATED ORGANIZATION. TOTAL COMPENSATION									5
6			OF \$10,010 FOR EACH SAM KLEIN AND H. RAYMOND KLEIN WAS									6
7			ALLOCATED AMONG THE SIX RELATED NURSING HOMES BASED									7
8			UPON 10 HOURS PER WEEK FOR SAM KLEIN AND 10 HOURS PER WEEK									8
9			FOR H. RAYMOND KLEIN.									9
10											10	
11											11	
12											12	
13								TOTAL	\$ 3,781		13	
* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.												
** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION												

						STATE OF ILLINOIS							Page 9		
Facility Name & ID Number		MEADOW MANOR			#	0011528	Report Period Beginning:			05/01/00	Ending:		04/30/01		
IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE															
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)															
	1	2	3		4	5	6		7	8	9	10			
													Reporting		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment	Date of	Amount of Note			Maturity Date	Interest Rate		Period		
		YES	NO		Required	Note	Original		Balance		(4 Digits)		Interest		
	A. Directly Facility Related														
	Long-Term														
1							\$		\$			\$		1	
2														2	
3														3	
4														4	
5														5	
	Working Capital														
6	FIRSTAR BANK		X	WORKING CAPITAL	INTEREST	08/25/99		289,726				VARIES		4,308	6
7	STOCKHOLDERS	X		WORKING CAPITAL	INTEREST	06/26/00		289,726		289,726	06/30/2010	6.0000		14,508	7
8														8	
9	TOTAL Facility Related						\$	579,452	\$	289,726			\$	18,816	9
	B. Non-Facility Related*														
10														10	
11														11	
12														12	
13														13	
14	TOTAL Non-Facility Related						\$		\$				\$		14
15	TOTALS (line 9+line14)						\$	579,452	\$	289,726			\$	18,816	15
* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.															
(See instructions.)															
** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.															
(See instructions.)															

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates

RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT									
FACILITY NAME		MEADOW MANOR				COUNTY		CHRISTIAN	
FACILITY IDPH LICENSE NUMBER		0011528							
CONTACT PERSON REGARDING THIS REPORT									
TELEPHONE		(217) 787-8530				FAX #:		(217) 787-9840	
A. Summary of Real Estate Tax Cos									
Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2000									
(A)		(B)		(C)		(D)			
Tax Index Number		Property Description		Total Tax		Tax		Applicable to Nursing Home	
1.	17-13-23-402-018	MEADOW MANOR WEST, INC		\$	904.72	\$		\$	904.72
2.	17-13-23-402-002	MEADOW MANOR, INC		\$	27,538.00	\$		\$	27,538.00
3.				\$		\$		\$	
4.				\$		\$		\$	
5.				\$		\$		\$	
6.				\$		\$		\$	
7.				\$		\$		\$	
8.				\$		\$		\$	
9.				\$		\$		\$	
10.				\$		\$		\$	
TOTALS				\$	28,442.72	\$		\$	28,442.72
B. Real Estate Tax Cost Allocation:									
Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services?									
		YES	X	NO					
If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used									
C. Tax Bills									
Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.									
Page 10A									

										STATE OF ILLINOIS																				Page 11																																																													
Facility Name & ID Number										MEADOW MANOR										#										0011528										Report Period Beginning:										05/01/00										Ending:										04/30/01																					
X. BUILDING AND GENERAL INFORMATION:																																																																																											
A.		Square Feet:										35,452										B. General Construction Type:										Exterior										MASONRY										Frame										STEEL & WOOD										Number of Stories										1									
C.		Does the Operating Entity?										X										(a) Own the Facility																				(b) Rent from a Related Organization.																				(c) Rent from Completely Unrelated Organization.																													
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)																																																																																											
D.		Does the Operating Entity?										X										(a) Own the Equipment																				(b) Rent equipment from a Related Organization.																				(c) Rent equipment from Completely Unrelated Organization.																													
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)																																																																																											
E.		List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)																																																																																									
		List entity name, type of business, square footage, and number of beds/units available (where applicable).																																																																																									
F.		Does this cost report reflect any organization or pre-operating costs which are being amortized?																				YES										X										NO																																																	
		If so, please complete the following:																																																																																									
		1. Total Amount Incurred:																				2. Number of Years Over Which it is Being Amortized:																																																																					
		3. Current Period Amortization:																				4. Dates Incurred:																																																																					
												Nature of Costs:																																																																															
												(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)																																																																															
XI. OWNERSHIP COSTS:																																																																																											
												1										2										3										4																																																	
		A. Land.										Use										Square Feet										Year Acquired										Cost																																																	
												1										NURSING HOME																				1963										\$										3,000										1																			
												2										NURSING HOME																				1984										\$										40,077										2																			
												3										TOTALS																														\$										43,077										3																			

Facility Name & ID Number						MEADOW MANOR						#	0011528				Report Period Beginning:				05/01/00		Ending:		Page 13 04/30/01			
XI. OWNERSHIP COSTS (continued)																												
C. Equipment Depreciation-Excluding Transportation. (See instructions.)																												
	Category of Equipment									1					Current Book Depreciation 2		Straight Line Depreciation 3		4	Component Life 5		Accumulated Depreciation 6						
					\$					Cost					\$			\$										
71	Purchased in Prior Years				\$					171,996					\$	14,538		\$	16,549		\$	2,011		VARIOUS	\$	98,207		71
72	Current Year Purchases									2,058						294			192			(102)		10		192		72
73	Fully Depreciated Assets									252,737														VARIOUS		252,737		73
74	ASSETS NO LONGER IN SERVICE									(79,615)																(79,615)		74
75	TOTALS				\$					347,176					\$	14,832		\$	16,741		\$	1,909			\$	271,521		75
D. Vehicle Depreciation (See instructions.)*																												
	1				Model, Make and Year 2				Year Acquired 3	4				Current Book Depreciation 5		Straight Line Depreciation 6		7		Life in Years 8		Accumulated Depreciation 9						
	Use								Cost									Adjustments										
76									\$					\$			\$			\$				\$			76	
77																											77	
78																											78	
79																											79	
80	TOTALS								\$					\$			\$			\$				\$			80	
E. Summary of Care-Related Assets																												
									Reference								Amount											
81	Total Historical Cost				(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12L, if applicable)								\$				1,478,613				81							
82	Current Book Depreciation				(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12L, if applicable)								\$				24,425				82							
83	Straight Line Depreciation				(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12L, if applicable)								\$				29,670				83 **							
84	Adjustments				(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12L, if applicable)								\$				5,245				84							
85	Accumulated Depreciation				(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12L, if applicable)								\$				1,241,497				85							
F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)																												
	1				2				Current Book Depreciation 3				Accumulated Depreciation 4				G. Construction-in-Progress											
	Description & Year Acquired				Cost												Description				Cost							
86					\$				\$				\$				86				92							
87																	87				93							
88																	88				94							
89																	89				95							
90																	90											
91	TOTALS				\$				\$				\$				91				*							
Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.																												
** This must agree with Schedule V line 30, column 8.																												

Facility Name & ID Number						MEADOW MANOR						STATE OF ILLINOIS # 0011528			Report Period Beginning:			05/01/00			Ending: 04/30/01		
XII. RENTAL COSTS																							
A. Building and Fixed Equipment (See instructions.)																							
1. Name of Party Holding Lease: N/A																							
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions.																							
YES NO																							
Year Constructed		1		Number of Beds		2		Date of Lease		3		Rental Amount		4		Total Years of Lease		5		Total Years Renewal Option*		6	
Original Building:									\$												3		
Additions																					4		
																					5		
																					6		
TOTAL									\$												7		
8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .																							
9. Option to Buy: YES NO Terms: *																							
B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)																							
15. Is Movable equipment rental included in building rental? YES NO																							
16. Rental Amount for movable equipment: \$ Description: (Attach a schedule detailing the breakdown of movable equipment)																							
C. Vehicle Rental (See instructions.)																							
Use		1		Model Year and Make		2		Monthly Lease Payment		3		Rental Expense for this Period		4									
									\$														
									\$														
									\$														
									\$														
TOTAL									\$														
* If there is an option to buy the building, please provide complete details on attached schedule.																							
** This amount plus any amortization of lease expense must agree with page 4, line 34.																							

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				STATE OF ILLINOIS				Page 19	
Facility Name & ID Number	MEADOW MANOR		# 0011528	Report Period Beginning:	05/01/00	Ending:	04/30/01		
XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.									
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.									
		I					2		
	Revenue	Amount			Expenses		Amount		
	A. Inpatient Care				A. Operating Expenses				
1	Gross Revenue -- All Levels of Care	\$ 1,931,958	1		31	General Services	509,004	31	
2	Discounts and Allowances for all Levels	()	2		32	Health Care	872,641	32	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,931,958	3		33	General Administration	512,465	33	
	B. Ancillary Revenue				B. Capital Expense				
4	Day Care		4		34	Ownership	71,856	34	
5	Other Care for Outpatients		5		C. Ancillary Expense				
6	Therapy		6		35	Special Cost Centers		35	
7	Oxygen	5,135	7		36	Provider Participation Fee	82,125	36	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,135	8		D. Other Expenses (specify):				
	C. Other Operating Revenue				37			37	
9	Payments for Education		9		38			38	
10	Other Government Grants		10		39			39	
11	Nurses Aide Training Reimbursements	6,441	11						
12	Gift and Coffee Shop		12		40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,048,091	40	
13	Barber and Beauty Care		13						
14	Non-Patient Meals		14		41	Income before Income Taxes (line 30 minus line 40)**	(94,144)	41	
15	Telephone, Television and Radio		15						
16	Rental of Facility Space	4,200	16		42	Income Taxes		42	
17	Sale of Drugs		17						
18	Sale of Supplies to Non-Patients		18		43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (94,144)	43	
19	Laboratory		19						
20	Radiology and X-Ray		20						
21	Other Medical Services		21						
22	Laundry	1,125	22						
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 11,766	23						
	D. Non-Operating Revenue								
24	Contributions		24		*	This must agree with page 4, line 45, column 4.			
25	Interest and Other Investment Income***	1,833	25						
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,833	26		**	Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.			
	E. Other Revenue (specify):****								
27	Settlement Income (Insurance, Legal, Etc.)		27						
28	VENDING \$2,053 ADMIT FEES \$750	2,803	28		***	See the instructions. If this total amount has not been offset			
28a	W/A \$62 Bad Debt Recovery \$370 Old Checks \$20	452	28a			against interest expense on Schedule V, line 32, please include a			
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,255	29			detailed explanation.			
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,953,947	30		****	Provide a detailed breakdown of "Other Revenue" on an attached sheet.			

										STATE OF ILLINOIS						Page 20					
Facility Name & ID Number				MEADOW MANOR						#		0011528		Report Period Beginning:		05/01/00		Ending:		04/30/01	
XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)																					
(This schedule must cover the entire reporting period.)																					
B. CONSULTANT SERVICES																					
		1		2**		3		4				1		2		3					
		# of Hrs.		# of Hrs.		Reporting Period		Average				Number		Total Consultant		Schedule V					
		Actually		Paid and		Total Salaries,		Hourly				of Hrs.		Cost for		Line &					
		Worked		Accrued		Wages		Wage				Paid &		Reporting		Column					
1	Director of Nursing		2,000	2,080	\$	43,147	\$	20.74	1												
2	Assistant Director of Nursing		1,300	1,372		22,918		16.70	2	35	Dietary Consultant		192	\$	3,481	1 - 3	35				
3	Registered Nurses		3,899	3,974		68,969		17.36	3	36	Medical Director		240		12,000	9 - 3	36				
4	Licensed Practical Nurses		21,833	22,848		288,763		12.64	4	37	Medical Records Consultant		17		485	10 - 3	37				
5	Nurse Aides & Orderlies		40,954	42,068		331,394		7.88	5	38	Nurse Consultant		8		1,427	10 - 3	38				
6	Nurse Aide Trainees		790	790		4,068		5.15	6	39	Pharmacist Consultant		48		1,200	10 - 3	39				
7	Licensed Therapist								7	40	Physical Therapy Consultant						40				
8	Rehab/Therapy Aides		1,883	1,958		16,780		8.57	8	41	Occupational Therapy Consultant						41				
9	Activity Director		1,977	1,993		11,720		5.88	9	42	Respiratory Therapy Consultant						42				
10	Activity Assistants		1,775	1,810		9,534		5.27	10	43	Speech Therapy Consultant						43				
11	Social Service Workers		1,808	1,885		18,710		9.93	11	44	Activity Consultant						44				
12	Dietician								12	45	Social Service Consultant		42		2,396	12 - 3	45				
13	Food Service Supervisor		2,025	2,276		24,386		10.71	13	46	Other(specify)						46				
14	Head Cook								14	47	ADMINISTRATIVE CONSULTANT		340		8,132	17 - 3	47				
15	Cook Helpers/Assistants		12,898	13,431		86,284		6.42	15	48							48				
16	Dishwashers								16												
17	Maintenance Workers		5,267	5,430		38,111		7.02	17	49	TOTAL (lines 35 - 48)		887	\$	29,121		49				
18	Housekeepers		6,698	6,847		37,368		5.46	18												
19	Laundry		4,077	4,220		24,691		5.85	19												
20	Administrator		2,000	2,080		49,631		23.86	20												
21	Assistant Administrator								21		C. CONTRACT NURSES										
22	Other Administrative								22				1		2		3				
23	Office Manager								23				Number				Schedule V				
24	Clerical		2,733	2,800		17,280		6.17	24				of Hrs.				Line &				
25	Vocational Instruction								25				Paid &		Total		Column				
26	Academic Instruction								26				Accrued		Contract		Wages				
27	Medical Director								27	50	Registered Nurses			\$						50	
28	Qualified MR Prof. (QMRP)								28	51	Licensed Practical Nurses									51	
29	Resident Services Coordinator								29	52	Nurse Aides									52	
30	Habilitation Aides (DD Homes)								30												
31	Medical Records								31	53	TOTAL (lines 50 - 52)			\$						53	
32	Other Health Care(specify)								32												
33	Other(specify) Utility Workers		2,579	2,590		13,724		5.30	33												
34	TOTAL (lines 1 - 33)		116,496	120,452	\$	1,107,478	*	\$	9.19	34											
* This total must agree with page 4, column 1, line 45.						** See instructions.															

									STATE OF ILLINOIS						Page 21
Facility Name & ID Number	MEADOW MANOR							#	0011528			Report Period Beginning:	05/01/00	Ending:	04/30/01
XIX. SUPPORT SCHEDULES															
A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions					
Name		Function		%	Amount	Description		Amount		Description		Amount			
RONALD DALLSTREAM		ADMINISTRATOR		0	\$ 49,631	Workers' Compensation Insurance		\$ 53,434		IDPH License Fee		\$ 200			
						Unemployment Compensation Insurance		11,653		Advertising: Employee Recruitment		4,571			
						FICA Taxes		83,426		Health Care Worker Background Check		636			
						Employee Health Insurance				(Indicate # of checks performed 53)					
						Employee Meals				SEE ATTACHED SCHEDULE		5,343			
						Illinois Municipal Retirement Fund (IMRF)*									
						HBV VACCINE		(8)		NURSING HOME MANAGERS ALLOC.		65			
TOTAL (agree to Schedule V, line 17, col. 1)							SECTION 125 PLAN		24,442						
(List each licensed administrator separately.)					\$	49,631	EMPLOYEE LIFE INSURANCE		2,284						
B. Administrative - Other						GIFT CERTIFICATES		1,380		Less: Non-allowable Dues		(60)			
Description					Amount	EMPLOYEE PARTY & APPRECIATION		550		Less: Public Relations Expense		(4,013)			
ADMINISTRATIVE CONSULTANT					\$	8,132	NURSING HOME MANAGERS ALLOCATION		10,086		Non-allowable advertising		()		
										Yellow page advertising		(847)			
						TOTAL (agree to Schedule V, line 22, col.8)		\$ 187,247		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 5,895			
TOTAL (agree to Schedule V, line 17, col. 3)					\$	8,132	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**				
(Attach a copy of any management service agreement)															
C. Professional Services						Description		Line #	Amount	Description		Amount			
Vendor/Payee		Type			Amount										
NURSING HOME MANAGERS		MANAGEMENT		\$	154,557	HVB VACCINE		22	\$ (8)	Out-of-State Travel		\$			
C S C		CORP. REPRESENTATION			463	GIFT CERTIFICATES		22	1,380						
						EMPLOYEE PARTY & APPREC.		22	550						
										In-State Travel					
										Administrator Mileage Reimbursement		525			
										Miscellaneous Mileage Reimbursement		207			
										Nursing Home Managers Allocation		1,414			
										Seminar Expense					
										Entertainment Expense		()			
TOTAL (agree to Schedule V, line 19, column 3)							TOTAL		\$ 1,922	(agree to Sch. V, line 24, col. 8)					
(If total legal fees exceed \$2500 attach copy of invoices.)					\$	155,020				TOTAL		\$ 2,146			
						* Attach copy of IMRF notifications				**See instructions.					

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MEADOW MANOR					#	0011528					05/01/00	-	04/30/01		PAGE 24
SCHEDULE V - PAGES 3 & 4															
LINE 27 - OTHER GENERAL ADMINISTRATION															
BAD DEBTS					\$	4,794									
SALES TAX						2,998									
FINES						7,215									
ILLINOIS RT TAX						<u>243</u>									
LINE 27 - COLUMN 3					\$	15,250									
COLUMN 5 - DETAIL OF RECLASSIFICATIONS															
FROM: OXYGEN					\$	<u>(5,135)</u>	10								
TO: ANCILLARY SERVICES					\$	5,135	39								
TO: ADMINISTRATIVE CONSULTANT MILEAGE					\$	861	17								
NURSE CONULTANT MILEAGE						<u>28</u>	10								
FROM: TRAVEL					\$	(889)	24								

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PROTEIN NAME	Y	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10	Y11	Y12	Y13	Y14	Y15	Y16	Y17	Y18	Y19	Y20	Y21	Y22	Y23	Y24	Y25	Y26	Y27	Y28	Y29	Y30	Y31	Y32	Y33	Y34	Y35	Y36	Y37	Y38	Y39	Y40	Y41	Y42	Y43	Y44	Y45	Y46	Y47	Y48	Y49	Y50	Y51	Y52	Y53	Y54	Y55	Y56	Y57	Y58	Y59	Y60	Y61	Y62	Y63	Y64	Y65	Y66	Y67	Y68	Y69	Y70	Y71	Y72	Y73	Y74	Y75	Y76	Y77	Y78	Y79	Y80	Y81	Y82	Y83	Y84	Y85	Y86	Y87	Y88	Y89	Y90	Y91	Y92	Y93	Y94	Y95	Y96	Y97	Y98	Y99	Y100	Y101	Y102	Y103	Y104	Y105	Y106	Y107	Y108	Y109	Y110	Y111	Y112	Y113	Y114	Y115	Y116	Y117	Y118	Y119	Y120	Y121	Y122	Y123	Y124	Y125	Y126	Y127	Y128	Y129	Y130	Y131	Y132	Y133	Y134	Y135	Y136	Y137	Y138	Y139	Y140	Y141	Y142	Y143	Y144	Y145	Y146	Y147	Y148	Y149	Y150	Y151	Y152	Y153	Y154	Y155	Y156	Y157	Y158	Y159	Y160	Y161	Y162	Y163	Y164	Y165	Y166	Y167	Y168	Y169	Y170	Y171	Y172	Y173	Y174	Y175	Y176	Y177	Y178	Y179	Y180	Y181	Y182	Y183	Y184	Y185	Y186	Y187	Y188	Y189	Y190	Y191	Y192	Y193	Y194	Y195	Y196	Y197	Y198	Y199	Y200	Y201	Y202	Y203	Y204	Y205	Y206	Y207	Y208	Y209	Y210	Y211	Y212	Y213	Y214	Y215	Y216	Y217	Y218	Y219	Y220	Y221	Y222	Y223	Y224	Y225	Y226	Y227	Y228	Y229	Y230	Y231	Y232	Y233	Y234	Y235	Y236	Y237	Y238	Y239	Y240	Y241	Y242	Y243	Y244	Y245	Y246	Y247	Y248	Y249	Y250	Y251	Y252	Y253	Y254	Y255	Y256	Y257	Y258	Y259	Y260	Y261	Y262	Y263	Y264	Y265	Y266	Y267	Y268	Y269	Y270	Y271	Y272	Y273	Y274	Y275	Y276	Y277	Y278	Y279	Y280	Y281	Y282	Y283	Y284	Y285	Y286	Y287	Y288	Y289	Y290	Y291	Y292	Y293	Y294	Y295	Y296	Y297	Y298	Y299	Y300	Y301	Y302	Y303	Y304	Y305	Y306	Y307	Y308	Y309	Y310	Y311	Y312	Y313	Y314	Y315	Y316	Y317	Y318	Y319	Y320	Y321	Y322	Y323	Y324	Y325	Y326	Y327	Y328	Y329	Y330	Y331	Y332	Y333	Y334	Y335	Y336	Y337	Y338	Y339	Y340	Y341	Y342	Y343	Y344	Y345	Y346	Y347	Y348	Y349	Y350	Y351	Y352	Y353	Y354	Y355	Y356	Y357	Y358	Y359	Y360	Y361	Y362	Y363	Y364	Y365	Y366	Y367	Y368	Y369	Y370	Y371	Y372	Y373	Y374	Y375	Y376	Y377	Y378	Y379	Y380	Y381	Y382	Y383	Y384	Y385	Y386	Y387	Y388	Y389	Y390	Y391	Y392	Y393	Y394	Y395	Y396	Y397	Y398	Y399	Y400	Y401	Y402	Y403	Y404	Y405	Y406	Y407	Y408	Y409	Y410	Y411	Y412	Y413	Y414	Y415	Y416	Y417	Y418	Y419	Y420	Y421	Y422	Y423	Y424	Y425	Y426	Y427	Y428	Y429	Y430	Y431	Y432	Y433	Y434	Y435	Y436	Y437	Y438	Y439	Y440	Y441	Y442	Y443	Y444	Y445	Y446	Y447	Y448	Y449	Y450	Y451	Y452	Y453	Y454	Y455	Y456	Y457	Y458	Y459	Y460	Y461	Y462	Y463	Y464	Y465	Y466	Y467	Y468	Y469	Y470	Y471	Y472	Y473	Y474	Y475	Y476	Y477	Y478	Y479	Y480	Y481	Y482	Y483	Y484	Y485	Y486	Y487	Y488	Y489	Y490	Y491	Y492	Y493	Y494	Y495	Y496	Y497	Y498	Y499	Y500	Y501	Y502	Y503	Y504	Y505	Y506	Y507	Y508	Y509	Y510	Y511	Y512	Y513	Y514	Y515	Y516	Y517	Y518	Y519	Y520	Y521	Y522	Y523	Y524	Y525	Y526	Y527	Y528	Y529	Y530	Y531	Y532	Y533	Y534	Y535	Y536	Y537	Y538	Y539	Y540	Y541	Y542	Y543	Y544	Y545	Y546	Y547	Y548	Y549	Y550	Y551	Y552	Y553	Y554	Y555	Y556	Y557	Y558	Y559	Y560	Y561	Y562	Y563	Y564	Y565	Y566	Y567	Y568	Y569	Y570	Y571	Y572	Y573	Y574	Y575	Y576	Y577	Y578	Y579	Y580	Y581	Y582	Y583	Y584	Y585	Y586	Y587	Y588	Y589	Y590	Y591	Y592	Y593	Y594	Y595	Y596	Y597	Y598	Y599	Y600	Y601	Y602	Y603	Y604	Y605	Y606	Y607	Y608	Y609	Y610	Y611	Y612	Y613	Y614	Y615	Y616	Y617	Y618	Y619	Y620	Y621	Y622	Y623	Y624	Y625	Y626	Y627	Y628	Y629	Y630	Y631	Y632	Y633	Y634	Y635	Y636	Y637	Y638	Y639	Y640	Y641	Y642	Y643	Y644	Y645	Y646	Y647	Y648	Y649	Y650	Y651	Y652	Y653	Y654	Y655	Y656	Y657	Y658	Y659	Y660	Y661	Y662	Y663	Y664	Y665	Y666	Y667	Y668	Y669	Y670	Y671	Y672	Y673	Y674	Y675	Y676	Y677	Y678	Y679	Y680	Y681	Y682	Y683	Y684	Y685	Y686	Y687	Y688	Y689	Y690	Y691	Y692	Y693	Y694	Y695	Y696	Y697	Y698	Y699	Y700	Y701	Y702	Y703	Y704	Y705	Y706	Y707	Y708	Y709	Y710	Y711	Y712	Y713	Y714	Y715	Y716	Y717	Y718	Y719	Y720	Y721	Y722	Y723	Y724	Y725	Y726	Y727	Y728	Y729	Y730	Y731	Y732	Y733	Y734	Y735	Y736	Y737	Y738	Y739	Y740	Y741	Y742	Y743	Y744	Y745	Y746	Y747	Y748	Y749	Y750	Y751	Y752	Y753	Y754	Y755	Y756	Y757	Y758	Y759	Y760	Y761	Y762	Y763	Y764	Y765	Y766	Y767	Y768	Y769	Y770	Y771	Y772	Y773	Y774	Y775	Y776	Y777	Y778	Y779	Y780	Y781	Y782	Y783	Y784	Y785	Y786	Y787	Y788	Y789	Y790	Y791	Y792	Y793	Y794	Y795	Y796	Y797	Y798	Y799	Y800	Y801	Y802	Y803	Y804	Y805	Y806	Y807	Y808	Y809	Y810	Y811	Y812	Y813	Y814	Y815	Y816	Y817	Y818	Y819	Y820	Y821	Y822	Y823	Y824	Y825	Y826	Y827	Y828	Y829	Y830	Y831	Y832	Y833	Y834	Y835	Y836	Y837	Y838	Y839	Y840	Y841	Y842	Y843	Y844	Y845	Y846	Y847	Y848	Y849	Y850	Y851	Y852	Y853	Y854	Y855	Y856	Y857	Y858	Y859	Y860	Y861	Y862	Y863	Y864	Y865	Y866	Y867	Y868	Y869	Y870	Y871	Y872	Y873	Y874	Y875	Y876	Y877	Y878	Y879	Y880	Y881	Y882	Y883	Y884	Y885	Y886	Y887	Y888	Y889	Y890	Y891	Y892	Y893	Y894	Y895	Y896	Y897	Y898	Y899	Y900	Y901	Y902	Y903	Y904	Y905	Y906	Y907	Y908	Y909	Y910	Y911	Y912	Y913	Y914	Y915	Y916	Y917	Y918	Y919	Y920	Y921	Y922	Y923	Y924	Y925	Y926	Y927	Y928	Y929	Y930	Y931	Y932	Y933	Y934	Y935	Y936	Y937	Y938	Y939	Y940	Y941	Y942	Y943	Y944	Y945	Y946	Y947	Y948	Y949	Y950	Y951	Y952	Y953	Y954	Y955	Y956	Y957	Y958	Y959	Y960	Y961	Y962	Y963	Y964	Y965	Y966	Y967	Y968	Y969	Y970	Y971	Y972	Y973	Y974	Y975	Y976	Y977	Y978	Y979	Y980	Y981	Y982	Y983	Y984	Y985	Y986	Y987	Y988	Y989	Y990	Y991	Y992	Y993	Y994	Y995	Y996	Y997	Y998	Y999	Y1000	Y1001	Y1002	Y1003	Y1004	Y1005	Y1006	Y1007	Y1008	Y1009	Y1010	Y1011	Y1012	Y1013	Y1014	Y1015	Y1016	Y1017	Y1018	Y1019	Y1020	Y1021	Y1022	Y1023	Y1024	Y1025	Y1026	Y1027	Y1028	Y1029	Y1030	Y1031	Y1032	Y1033	Y1034	Y1035	Y1036	Y1037	Y1038	Y1039	Y1040	Y1041	Y1042	Y1043	Y1044	Y1045	Y1046	Y1047	Y1048	Y1049	Y1050	Y1051	Y1052	Y1053	Y1054	Y1055	Y1056	Y1057	Y1058	Y1059	Y1060	Y1061	Y1062	Y1063	Y1064	Y1065	Y1066	Y1067	Y1068	Y1069	Y1070	Y1071	Y1072	Y1073	Y1074	Y1075	Y1076	Y1077	Y1078	Y1079	Y1080	Y1081	Y1082	Y1083	Y1084	Y1085	Y1086	Y1087	Y1088	Y1089	Y1090	Y1091	Y1092	Y1093	Y1094	Y1095	Y1096	Y1097	Y1098	Y1099	Y1100	Y1101	Y1102	Y1103	Y1104	Y1105	Y1106	Y1107	Y1108	Y1109	Y1110	Y1111	Y1112	Y1113	Y1114	Y1115	Y1116	Y1117	Y1118	Y1119	Y1120	Y1121	Y1122	Y1123	Y1124	Y1125	Y1126	Y1127	Y1128	Y1129	Y1130	Y1131	Y1132	Y1133	Y1134	Y1135	Y1136	Y1137	Y1138	Y1139	Y1140	Y1141	Y1142	Y1143	Y1144	Y1145	Y1146	Y1147	Y1148	Y1149	Y1150	Y1151	Y1152	Y1153	Y1154	Y1155	Y1156	Y1157	Y1158	Y1159	Y1160	Y1161	Y1162	Y1163	Y1164	Y1165	Y1166	Y1167	Y1168	Y1169	Y1170	Y1171	Y1172	Y1173	Y1174	Y1175	Y1176	Y1177	Y1178	Y1179	Y1180	Y1181	Y1182	Y1183	Y1184	Y1185	Y1186	Y1187	Y1188	Y1189	Y1190	Y1191	Y1192	Y1193	Y1194	Y1195	Y1196	Y1197	Y1198	Y1199	Y1200	Y1201	Y1202	Y1203	Y1204	Y1205	Y1206	Y1207	Y1208	Y1209	Y1210	Y1211	Y1212	Y1213	Y1214	Y1215	Y1216	Y1217	Y1218	Y1219	Y1220	Y1221	Y1222	Y1223	Y1224	Y1225	Y1226	Y1227	Y1228	Y1229	Y1230	Y1231	Y1232	Y1233	Y1234	Y1235	Y1236	Y1237	Y1238	Y1239	Y1240	Y1241	Y1242	Y1243	Y1244	Y1245	Y1246	Y1247	Y1248	Y1249	Y1250	Y1251	Y1252	Y1253	Y1254	Y1255	Y1256	Y1257	Y1258	Y1259	Y1260	Y1261	Y1262	Y1263	Y1264	Y1265	Y1266	Y1267	Y1268	Y1269	Y1270	Y1271	Y1272	Y1273	Y1274	Y1275	Y1276	Y1277	Y1278	Y1279	Y1280	Y1281	Y1282	Y1283	Y1284	Y1285	Y1286	Y1287	Y1288	Y1289	Y1290	Y1291	Y1292	Y1293	Y1294	Y1295	Y1296	Y1297	Y1298	Y1299	Y1300	Y1301	Y1302	Y1303	Y1304	Y1305	Y1306	Y1307	Y1308	Y1309	Y1310	Y1311	Y1312	Y1313	Y1314	Y1315	Y1316	Y1317	Y1318	Y1319	Y1320	Y1321	Y1322	Y1323	Y1324	Y1325	Y1326	Y1327	Y1328	Y1329	Y1330	Y1331	Y1332	Y1333	Y1334	Y1335	Y1336	Y1337	Y1338	Y1339	Y1340	Y1341	Y1342	Y1343	Y1344	Y1345
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[illegible]

ALLOCATION PERCENTAGES USED ON PAGE 28														
MEADOW MANOR				#	0011528		PAGE 29			05/01/00			04/30/01	
OCCUPIED														
DAYS	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL						
2000														
JANUARY	2453	1828	2186	1874	663	1482	2008	12494						
FEBRUAR	2205	1686	2168	1746	597	1442	1996	11840						
MARCH	2383	1773	2434	1904	604	1569	2285	12952						
APRIL	2273	1671	2387	1783	641	1496	2155	12406						
MAY	2301	1691	2252	1910	600	1448	2073	12275						
JUNE	2211	1730	2175	1793	603	1426	1906	11844						
JULY	2317	1823	2396	1846	652	1459	1889	12382						
AUGUST	2249	1817	2342	1861	673	1516	1966	12424						
SEPTEM	2163	1790	2174	1709	665	1606	1899	12006						
OCTOBER	2249	1815	2246	1709	627	1766	1986	12398						
NOVEMBE	2288	1675	2189	1590	594	1689	2002	12027						
DECEMBE	2294	1678	2228	1642	668	1664	2130	12304						
TOTAL	27386	20977	27177	21367	7587	18563	24295	147352						
								147352						
ALLOCATION														
PERCENTAGE		D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL						
2000														
JANUARY		19.63%	14.63%	17.50%	20.31%	11.86%	16.07%	100.00%						
FEBRUARY		18.62%	14.24%	18.31%	19.79%	12.18%	16.86%	100.00%						
MARCH		18.40%	13.69%	18.79%	19.36%	12.11%	17.64%	100.00%						
APRIL		18.32%	13.47%	19.24%	19.54%	12.06%	17.37%	100.00%						
MAY		18.75%	13.78%	18.35%	20.45%	11.80%	16.89%	100.00%						
JUNE		18.67%	14.61%	18.36%	20.23%	12.04%	16.09%	100.00%						
JULY		18.71%	14.72%	19.35%	20.17%	11.78%	15.26%	100.00%						
AUGUST		18.10%	14.62%	18.85%	20.40%	12.20%	15.82%	100.00%						
SEPTEMBER		18.02%	14.91%	18.11%	19.77%	13.38%	15.82%	100.00%						
OCTOBER		18.14%	14.64%	18.12%	18.84%	14.24%	16.02%	100.00%						
NOVEMBER		19.02%	13.93%	18.20%	18.16%	14.04%	16.65%	100.00%						
DECEMBER		18.64%	13.64%	18.11%	18.77%	13.52%	17.31%	100.00%						
OCCUPIED														
DAYS	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL						
2001														
JANUARY	2,278	1,698	2,136	1,630	595	1,701	2,074	12,112						
FEBRUAR	2,100	1,570	2,067	1,408	518	1,538	1,875	11,076						
MARCH	2,277	1,656	2,349	1,605	558	1,660	2,366	12,471						
APRIL	2,198	1,578	2,311	1,461	560	1,563	2,419	12,090						
MAY	2,210	1,727	2,404	1,535	543	1,568	2,491	12,478						
JUNE	2,141	1,615	2,368	1,691	304	1,673	2,417	12,209						
JULY	2,114	1,602	2,434	2,119		1,702	2,441	12,412						
AUGUST														
SEPTEM														
OCTOBER														
NOVEMBER														
DECEMBER														
TOTAL	15,318	11,446	16,069	11,449	3,078	11,405	16,083	84,848						
								84,848						
ALLOCATION														
PERCENTAGE		D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL						
2001														
JANUARY		18.81%	14.02%	17.64%	18.37%	14.04%	17.12%	100.00%						
FEBRUARY		18.96%	14.17%	18.66%	17.39%	13.89%	16.93%	100.00%						
MARCH		18.26%	13.28%	18.84%	17.34%	13.31%	18.97%	100.00%						
APRIL		18.18%	13.05%	19.11%	16.72%	12.93%	20.01%	100.00%						
MAY		17.71%	13.84%	19.27%	16.65%	12.57%	19.96%	100.00%						
JUNE		17.54%	13.23%	19.40%	16.34%	13.70%	19.80%	100.00%						
JULY		17.03%	12.91%	19.61%	17.07%	13.71%	19.67%	100.00%						